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PERF PERF

Please Type or Print

REQUEST FOR PRIOR APPROVAL FOR VISUAL AIDS

Please Type or Print

1. Recipient Name - Last	2. First	3. MI	4. Sex M ☐ F ☐	5. Recipient I.D. Number
6. Date of Birth	7. Date of Refraction	8. Name of Prescriber		9. Diagnosis & ICD-9 Codes

10. Department Use Only

Decision: Agent: Date:

11. Frame: Standard Medicaid Selection	12. * Frame: Exception	13. * Exceptional Services
Metal ☐ Zyl ☐ Combination ☐	Invoice Cost _____ Also Fill In Blocks 22, 23, 24, 25 & 26 Include Manufacturer In Block 22	Gray Tint 1 2 Sun Photogray ☐ Repair or Replacement ☐ Pink Tint 1 2 Ultraviolet Filter ☐ Other: _____

14. * Please provide documentation/medical justification for approval of requests for exceptional (*) services.

Order (circle one)	15. Complete Glasses	16. Lenses Only	17. Frame Only	18. * Frame to Follow	19. R Lens Only	20. L Lens Only	21. Lens circumference R _____ L _____
Frame	22. Manufacturer/Frame Name or Number		23. Eye Size	24. Bridge Size	25. Temple Length	26. Color	
Lenses (circle one)	27. Single Vision	28. ST 28 (Bifocals)	29. *ST 35 (Bifocals)	30. Round (Bifocals)	31. *Executive (Bifocals)	32. * 7X28 (Trifocals)	33. * 8X35 (Trifocals)	34. Cataract Lens	35. * Other
Material (circle one)	36. CR39	37. * Polycarbonate	38. * Hi-Index	39. Glass	40. * Other				

	41. Sphere	42. Cylinder	43. Axis	44. Prism	45. Base	46. Add	47. Seg. Ht.	48. Distance P.D.	49. Near
R									
L									

PROOF

* Contact Lenses: Evaluation for approval based on documentation of medical diagnosis and necessity. Slab Off ☐

50. Manufacturer/Lens Name	53. Please specify reason for contact lens request		Fresnell Prism	Power	Base
51. Lens Type (DW, RGP, etc.)	Keratoconus ☐	Significant Anisometropia ☐	R		
52. Invoice Cost	Aphakia ☐	Significant Progressive Myopia ☐	L		
	* Other (Attach documentation of medical necessity) ☐				

54. Special Instruction for Medicaid Contractor Laboratory

55. Initial Fitting Optician/Technician (print)	Recipient notified to pick up visual aids				64. Inspected by
	61. Caller's Initials				65. Date Inspected
56. Initial Fitting Optician/Technician (signature) Fitting Date	62. Date				66. Dispensed by
57. Provider Phone Number ( ) 58. Submission Date	63. Method	Phone ☐ Mail ☐	Phone ☐ Mail ☐	Phone ☐ Mail ☐	67. Date Dispensed

59. Provider Address

60. Provider Number

Signature denotes receipt of visual aid outlined above

68. Printed name of Parent/Guardian (if recipient is under 18)

69. Signature of Recipient or Parent/Guardian (if recipient is under 18)

70. Relationship to recipient (if recipient is under 18) 71. Date

FISCAL AGENT COPY **Prior Approval Forms should be submitted daily** 372-017 (05/2006)

SCREENING @ 12%

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PERF PERF

REMINDERS FOR PRIOR APPROVAL REQUESTS

TYPE, PRINT, OR STAMP PROVIDER NAME, PROVIDER NUMBER, ADDRESS, AND TELEPHONE NUMBER WITH AREA CODE ON ALL COPIES

REQUEST FOR PRIOR APPROVAL FORM

Submit Fiscal Agent, Contractor and Provider Copy to:

EDS
P.O. Box 31188
Raleigh, North Carolina 27622

VISUAL AID CLAIM FORM (CMS-1500)

Submit to:

EDS
P.O. Box 30968
Raleigh, North Carolina 27622

Retain the provider office copy for your files.

LIMITATIONS One eye refraction per year for recipients under age 21, one refraction every two years for recipients 21 years and older. The same limitations apply to visual aids. Requests for additional refractions must be submitted in writing on the general Prior Approval form #372-118. Document medical necessity; surgery, injury, visual loss, *diabetes, etc.

*Diabetes: Attach physician's report (letter/documentation) that the patient's diabetic condition is controlled/stabilized.

A recipient's refractive history can be obtained from EDS by calling 1-800-723-4337 or 919-851-8888. If the recipient is eligible and has no refractive history within the 1-2 year time limitation, a verbal authorization number will be given to the provider. The 13 digit authorization number should be kept with the recipient's file.

Requests for additional visual aids must include documentation of medical necessity (post-cataract, medical condition, pharmaceutical change, etc.) and documentation of both visual acuity with current visual aid and proposed visual acuity with new prescription. Generally, a change in power of + or -.31 diopter or greater is required for approval of new lenses.

NON-COVERED SERVICES:

Cosmetic Lenses
Sport Straps
Gradient Tints
Safety Glasses
Rimless Frames
Blended Lenses
Transitions Lenses
Anti-reflective Coating
Progressive Lenses
Initialing/Engraving
Drilling or Grooving Lenses

EXCEPTIONAL SERVICES REQUIRE MEDICAL JUSTIFICATION This list is not all-inclusive.

Gray Tint 1, 2 or Gray Sun
Pink Tint 1 or 2
Photogray
UV Filter
ST-35, Executive or Trifocal Lenses
Polycarbonate or Hi Index
Contact Lenses

Web site for Optical Services Policy:
www.dhhs.state.nc.us/dma/optical.htm
click on: N.C. Division of Medical Assistance
click on: Chapter 4 - Optical Services

Web site for Medicaid Bulletin articles:
http://www.dhhs.state.nc.us/dma/bulletin.htm
Select year and month of bulletin article

Bulletin articles that are issued after the original printing date of the Optical Services Policy, supersede the information printed in the policy.

BACK (HEAD to HEAD)

Block	Field Name	Description
1	Recipient Name- Last	Print the recipient's last name as it appears on the MID card.
2	Recipient Name- First	Print the recipient's first name as it appears on the MID card.
3	Middle Initial	Print the recipient's middle initial as it appears on the MID card.
4	Sex	Mark the recipient's gender.
5	Recipient I.D. Number	Enter the recipient's 10 character MID number, which is found on the Medicaid card. (The MID is a 9 digit number followed by an alpha character.)
6	Date of Birth	Enter the recipient's date of birth in MMDDYY format.
7	Date of Refraction	Enter the date of the most recent refraction.
8	Name of Prescriber	Print the name of the prescribing doctor.
9	Diagnosis and ICD-9 Codes	Enter the diagnosis code and the ICD-9 code(s).
10	For Department Use Only	For fiscal agent prior authorization only.
11	Frame: Standard Medicaid Selection	Mark frame type.
12	*Frame Exception	Fill in the frame information in boxes 22, 23, 24, 25 and 26. Fill in the manufacturer's invoice cost of frame.
13	*Exceptional Services	An asterisk (*) Denotes exceptional services which require documentation of medical necessity. Clearly mark choice of exceptional service.
14	*Please provide documentation…	Provide documentation for requested exceptional services; may be recorded on, or attached to, the Prior Approval form.
15	Complete Glasses	Circle when complete glasses are requested.
16	Lenses Only	Circle when lenses only are requested.
17	Frame Only	Circle when Medicaid Contractor Laboratory is to supply the frame only.
18	*Frame to Follow	Frame will be forwarded from the provider to the Medicaid Contractor Laboratory. Circle when frame is to follow- requires prior approval.
19	R Lens only	Circle when right lens only is required.
20	L Lens only	Circle when left lens only is required.
21	Lens Circumference Measurement	Enter Lens circumference measurement for lens only orders.
22	Manufacturer/Frame Name or Number	Print frame manufacturer and name or model number.
23	Eye Size	Enter frame size (A measurement).
24	Bridge Size	Enter bridge size. (DBL measurement).
25	Temple Length	Enter temple length.
26	Color	Enter frame color.
27	Single Vision	Circle for single vision lenses.
28	ST28	Circle for ST28 bifocals.
29	*ST35	ST35 bifocal- requires documentation.
30	Round Segment	Circle for round bifocals.
31	*Executive	Executive bifocal- requires documentation.
32	*7X28	7X28 trifocal- requires documentation.
33	*8X35	8X35 trifocal- requires documentation.
34	Cataract Lens	Circle and specify lens type.

35	*Other	Specify lens type- requires documentation.
36	CR39	Circle for CR39.
37	*Polycarbonate	Circle for polycarbonate- age 7 and above requires documentation.
38	*Hi-index	Circle for Hi-index- requires documentation.
39	Clear glass	Circle for clear glass.
40	*Other	Enter other lens choice-requires documentation.
41	Sphere	Enter sphere power.
42	Cylinder	Enter cylinder power.
43	Axis	Enter axis.
44	Prism	Enter amount of prism.
45	Base	Enter direction of base.
46	Add	Enter bifocal power.
47	Seg. Ht.	Enter bifocal segment height.
48	Distance P.D.	Enter distance pupillary distance.
49	Near P.D.	Enter near pupillary distance.
50	Manufacturer/Lens Name	Enter contact lens manufacturer and lens name.
51	Lens Type	Enter contact lens type: (i.e. daily wear, RGP, etc.)
52	Invoice Cost	Enter manufacturer's invoice cost of contact lenses.
53	Reason for CL request	Check reason for contact lenses request, if '*Other", attach letter of medical necessity/justification.
54	Special Instructions for Mediciad Contractor/Laboratory	Enter special instructions for lab. (example: note different signs, etc.)
55	Initial Fitting Optician/Technician	Print Name
56	Initial Fitting Optician/Technician	Signature and Fitting Date
57	Phone Number	Enter provider's area code and phone number.
58	Submission Date	Enter date prior approval form is submitted.
59	Provider Address	Print or stamp provider's address.
60	Provider Number	Enter provider's 7 digit Medicaid number.
61	Caller's Initials	Print initials of person notifying recipient to pick up visual aids.
62	Date	Enter date(s) recipient is notified.
63	Method	Enter method used to notify recipient: (i.e. phone, mail, etc.)
64	Inspected by	Print name of person performing inspection of Medicaid glasses.
65	Date Inspected	Enter date glasses were inspected.
66	Dispensed by	Print name of dispenser.
67	Date Dispensed	Dispenser to enter dispense date.
68	Recipient Name	Printed name of person picking up glasses- if other than recipient.
69	Signature	Signature of person picking up glasses (recipient if over 18, parent or guardian if recipient is under 18)
70	If recipient is under 18...	Print relationship to recipient (parent, guardian, etc.)
71	Date	Recipient, Parent/Guardian should enter date glasses are received.